Exhibit 3(e): Bedford

- J0640

EMPLOYEE	DEPENDENT (IF APPLICABLE)	RELATIONSHIP
		S

PROVIDER TAX I.D. #:	PATIENT ACCOUNT #
042767880	10

NO 0588583

12/20/2002
DATE ISSUED

SHEET METAL WORKERS' NATIONAL HEALTH FUND
P.O. BOX 1449 • GOODLETTSVILLE, TN 37070-1449

PAY **********95DOLLARS AND 20CENTS** DOLLARS $ *****95.20**

TO THE ORDER OF
HALLMARK HEALTH SYSTEM, INC.
100 HOSPITAL RD
MALDEN , MA 02148

0588583

AUTHORIZED SIGNATURE

NON NEGOTIABLE

AUTHORIZED SIGNATURE

SunTrust Bank, Nashville
Nashville, Tennessee 37228

⑈00588583⑈ ⑆064000046⑆ 702139030 2⑈

SHEET METAL WORKERS' NATIONAL HEALTH FUND

P.O. Box 1449
Goodlettsville, Tennessee 37070-1449
Toll-Free 800-831-4914 Phone (615) 859-0131

SMW+ PROGRAM

EXPLANATION OF BENEFITS

FROM DATE	TO DATE	CHARGES SUBMITTED	NON COVERED	CHARGES ALLOWED	COVERED CHARGES	AMOUNT PAID
10/01/2002	10/31/2002	2720.00	.00	95.20	95.20	95.20
		2720.00	.00	95.20	95.20	95.20

NON-COVERED CODES:

REDACTED

COMMENTS:

PROVIDER: HALLMARK HEALTH SYSTEM, INC.
PARTICIPANT
CDF CLAIM NUMBER: 2005050

BRADFORD MA 01835

Processed by SOUTHERN BENEFIT ADMINISTRATORS, INC.

APPROVED OMB NO. 0938-0279

HALLMARK HEALTH 100 HOSPITAL RD MALDEN 1 MA02148 0000000000	2							3 PATIENT CONTROL NUMBER		4 TYPE OF BILL 131
	5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV'D.	8 N-C'D.	9 C-I'D.	10 L-R'D.	11		
	0042767880	100102	103102	30	0	0	0			

12 PATIENT'S NAME

13 PATIENT'S ADDRESS

BRADFORD, MA 01835-

14 BIRTHDATE	15 SEX	16 MS	17 ADMISSION DATE	18 HR	19 TYP	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24	25	26	27	28	29	30	31
02251947	F	M	10012002	07	3	2	99	01	H0081528								

32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE DATE	36 CODE	36 OCCURRENCE SPAN FROM	THROUGH	37
											A B C

38 SHEET METAL WORKERS

REDACTED

	39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT
a	88	2405.80			A2	95.20
b						
c						
d						

42 REV.CD	43 DESCRIPTION	44 HCPCS/RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0250	PHARMACY		102902	1	400	000	
0280	ONCOLOGY	99212	100102	1	7300	7300	
0280	ONCOLOGY	99214	100802	1	10600	000	
0280	ONCOLOGY	99212	101502	1	7300	7300	
0280	ONCOLOGY	99213	102202	1	9100	000	
0280	ONCOLOGY	99212	102902	1	7300	7300	
0300	LABORATORY	G0001	100102	1	1400	000	
0300	LABORATORY	G0001	101502	1	1400	000	
0300	LABORATORY	G0001	102902	1	1400	000	
0305	LAB/HEMATOLOGY	85025	100102	1	3000	000	
0305	LAB/HEMATOLOGY	85025	101502	1	3000	000	
0305	LAB/HEMATOLOGY	85025	102902	1	3000	000	
0331	CHEMOTHER/INJ	Q0083	100102	1	27800	000	
0331	CHEMOTHER/INJ	Q0083	100802	1	27800	000	
0331	CHEMOTHER/INJ	Q0083	101502	1	27800	000	
0331	CHEMOTHER/INJ	Q0083	102902	1	27800	000	
0636	DRUGS/DETAIL CODE	J0640	100102	1	6000	000	
0636	DRUGS/DETAIL CODE	J9190	100102	2	2600	000	
0636	DRUGS/DETAIL CODE	Q0166	100102	1	17800	000	
0636	DRUGS/DETAIL CODE	J0640	100802	1	6000	000	
0636	DRUGS/DETAIL CODE	J9190	100802	2	2600	000	
0636	DRUGS/DETAIL CODE	Q0166	100802	1	17800	000	

50 PAYER	51 PROVIDER NO.	52 REL. INFO.	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
PAGE: 01 OF 02						
MEDICARE PART A	220070	Y	Y	240580		
SHEET METAL WORKERS		Y	Y		9520	
	DUE FROM PATIENT					

58 INSURED'S NAME	59 P REL	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
	01		DISABLED	UNKNOWN
	02		DISABLED	UNKNOWN

63 TREATMENT AUTHORIZATION CODES	64 ES	65 EMPLOYER NAME	66 EMPLOYER LOCATION
			EOB ATTACHED

67 PRIN.DIAG CD.	68 CODE	69 CODE	70 CODE	OTHER DIAG. CODES 71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM.DIAG.CD.	77 E-CODE	78
1539											

79 PC	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER CODE	PROCEDURE DATE
9						
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER CODE	PROCEDURE DATE

82 ATTENDING PHYS ID B72551
PENNACCHIO JOSEPH

83 OTHER PHYS ID
A

OTHER PHYS ID B72551
B PENNACCHIO JOSEPH

84 REMARKS SHEET METAL WORKERS
PO BOX 1449
GOODLETTSVILLE, TN 37070-1449

85 PROVIDER REPRESENTATIVE
KATHY MARINELLI

86 DATE
11022002

APPROVED OMB NO. 0938-279

HALLMARK HEALTH 100 HOSPITAL RD MALDEN 1 MA02148 0000000000	2			3 PATIENT CONTROL NUMBER						4 TYPE OF BILL 131
	5 FED. TAX NO. 0042767880	6 STATEMENT COVERS PERIOD FROM 100102	THROUGH 103102	7 COV'D. 30	8 N-O.D. 0	9 C-I.D. 0	10 L-R.D. 0	11		
12 PATIENT'S NAME	13 PATIENT'S ADDRESS									
				BRADFORD, MA 01835-						

14 BIRTHDATE	15 SEX	16 MS	17 DATE	18 HR	19 TYP	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24	25	26	27	28	29	30	31
02251947	F	M	10012002	07	3	2	99	01	H0081528								

32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE DATE	36 CODE	36 OCCURRENCE SPAN FROM	THROUGH	37
											A B C

38 SHEET METAL WORKERS

REDACTED

39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT
a 88	2405.80			A2	95.20
b					
c					
d					

42 REV.CD	43 DESCRIPTION	44 HCPCS/RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0636	DRUGS/DETAIL CODE	J0640	101502	1	6000	000	
0636	DRUGS/DETAIL CODE	J9190	101502	2	2600	000	
0636	DRUGS/DETAIL CODE	Q0166	101502	1	17800	000	
0636	DRUGS/DETAIL CODE	J0640	102902	1	6000	000	
0636	DRUGS/DETAIL CODE	J9190	102902	2	2600	000	
0636	DRUGS/DETAIL CODE	Q0166	102902	1	17800	000	
0001	TOTAL CHARGES			32	272000	21900	

50 PAYER	51 PROVIDER NO.	52 REL. CALIF.	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
PAGE: 02 OF 02						
MEDICARE PART A	220070	Y	Y	240580		
SHEET METAL WORKERS		Y	Y		9520	
	DUE FROM PATIENT					

57 INSURED'S NAME	59 P.REL	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
	01		DISABLED	UNKNOWN
	02		DISABLED	UNKNOWN

63 TREATMENT AUTHORIZATION CODES	64 ES	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN.DIAG CD.	68 CODE	69 CODE	70 CODE	OTHER DIAG CODES 71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM.DIAG.CD.	77 E-CODE	78
1539											

79 PC	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
9						
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE

82 ATTEND PHYS. ID B72551
PENNACCHIO JOSEPH
83 OTHER PHYS. ID A
OTHER PHYS. ID B72551 B
PENNACCHIO JOSEPH
87 PROVIDER REPRESENTATIVE KATHY MARINELLI 88 DATE 11072002

84 REMARKS SHEET METAL WORKERS
PO BOX 1449
GOODLETTSVILLE, TN 37070-1449

MEDICARE NATIONAL STANDARD INTERMEDIARY REMITTANCE ADVICE

HALLMARK HEALTH SYSTEMS
100 HOSPITAL ROAD
MALDEN MA 02148

PROVIDER: 220070 MEDICARE
ENDING: 10/31/2002
BILL TYPE: 131

NAME:
HIC: PCN: V19070457 1
MRN: H0081528 ICN: 1231539763

SERVICE: 10/01/2002 THRU 10/31/2002
MEDICARE PAYMENT DATE: 12/03/2002
PAT STAT: 01 CLAIM STAT: 1

CHARGES		PPS DATA		PAYMENT DATA	
REPORTED	2720.00	DRG	000	REIMB RATE	0.00
NON-COVERED	219.00	DRG AMOUNT	0.00	PROF COMP	0.00
DENIED	0.00	DRG/OPERATION	0.00	PERDIEM	0
		DRG/CAPITAL	0.00	INTEREST	0.00
		OUTLIER( )	0.00		
DAYS					
		BLOOD DEDUCT	0.00		
COVERED DAYS	0000	TOTAL DEDUCT	0.00	CONT ADJ AMT	1957.70
NON-COVERED DAYS	0000	CO-INSURANCE	95.20	NET REIMB AMT	448.10

REDACTED

Exhibit 3(f): Boehringer

- J9000
- J0640
- J9260

Date: 3/08/2004
Time: 4:25PM

Page: 1

SPRINGFIELD MEDICAL ASSOC INC
PO BOX 219
WINDSOR, CT 06095
Phone: (800) 883-5985

MEDICARE REMITTANCE NOTICE

Provider/Clinic#: N51714

Check No/EFT Trace No: 127340082
Date Paid: 2/26/2004

REDACTED

NAME:

PERF PROV.	SERVICE DATES	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PAID AMT.
N51714	2/02/2004 2/02/2004	11	001	J3490		405.00	307.80	0.00	61.56	97.20	246.24
PT Respon: 61.56				Claim Totals:		405.00	307.80	0.00	61.56	97.20	246.24

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

MAIL TO:
SHEET METAL WORKERS NAT'L HEA
P O BOX 1449
GOODLETTSVILLE, TN 37070

APPROVED OMB-0938-0008
RETURN
SMWN 0001
00111
SECONDARY

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE | MEDICAID | CHAMPUS | CHAMPVA | GROUP HEALTH PLAN | FECA BLK LUNG | OTHER
(Medicare #) | (Medicaid #) | (Sponsor's SSN) | (VA File #) | (SSN or ID) | (SSN) | [X] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY: 04 20 1937 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [X] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: SPRINGFIELD
STATE: MA
ZIP CODE: 01118-0000
TELEPHONE (Include Area Code)

8. PATIENT STATUS: Single [ ] Married [X] Other [ ]
Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: SPRINGFIELD
STATE: MA
ZIP CODE: 01118-0000
TELEPHONE (INCLUDE AREA CODE)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: [redacted] SEX: M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: 04 20 1937 SEX: M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME [redacted]

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: SHEET METAL WORKERS NAT'L

d. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICARE - MASS

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO [ ] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 11-17-03

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY
FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: HETZEL, PAUL C.

17a. I.D. NUMBER OF REFERRING PHYSICIAN: A68203

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY
FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 174.9
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 02 02 04	02 02 04	11	1	99214	25	1	127 00	1				
2 02 02 04	02 02 04	11	5	96408		1	175 00	1				
3 02 02 04	02 02 04	11	5	96410		1	245 00	1				
4 02 02 04	02 02 04	11	1	90780	59	1	135 00	1				
5												
6 [redacted]												

25. FEDERAL TAX I.D. NUMBER: 04-3498186 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE: $ 682 00

29. AMOUNT PAID: $ 555 21

30. BALANCE DUE: $ 126 79

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
HETZEL, PAUL M.D.
LIC.# 039373 03/04/04
SIGNATURE OF PHYSICIAN OR SUPPLIER DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
SPRINGFIELD MEDICAL ASSOC
2150 MAIN ST, STE 1000
SPRINGFIELD, MA 01104-000

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
SPRINGFIELD MEDICAL ASSOC
P.O. BOX 219
WINDSOR, CT 06095-0000
PIN# GRP#

MC (APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) 03/04/2004 4001842

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Date: 3/08/2004
Time: 4:25PM

Page: 1

SPRINGFIELD MEDICAL ASSOC INC
PO BOX 219
WINDSOR, CT 06095
Phone: (800) 883-5985

MEDICARE REMITTANCE NOTICE

Provider/Clinic#: N51714

Check No/EFT Trace No: 12734008 REDACTED
Date Paid: 2/26/2004

NAME: T

PERF PROV.	SERVICE DATES	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PAID AMT.
N51714	2/02/2004 2/02/2004	11	001	96410		245.00	243.10	0.00	48.62	1.90	194.48
N51714	2/02/2004 2/02/2004	11	001	96408		175.00	172.76	0.00	34.55	2.24	138.21
N51714	2/02/2004 2/02/2004	11	001	90780	59	135.00	130.86	0.00	26.17	4.14	104.69
N51714	2/02/2004 2/02/2004	11	001	99214	25	127.00	87.24	0.00	17.45	39.76	69.79
PT Respon: 126.79						Claim Totals:	682.00	633.96	0.00	126.79	48.04	507.17

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

MAIL TO:
SHEET METAL WORKERS NAT'L HEA
P O BOX 1449
GOODLETTSVILLE, TN 37070

APPROVED OMB-0938-0008
RETURN
SMWN 0001
00113
SECONDARY

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID) X

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY: 04 20 1937 | SEX: M | F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse X | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY: SPRINGFIELD | STATE: MA

8. PATIENT STATUS: Single | Married X | Other

CITY: SPRINGFIELD | STATE: MA

ZIP CODE: 01118-0000 | TELEPHONE (Include Area Code)

Employed | Full-Time Student | Part-Time Student

ZIP CODE: 01118-0000 | TELEPHONE (INCLUDE AREA CODE)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS): YES | NO X

a. INSURED'S DATE OF BIRTH MM DD YY: 03 07 1937 | SEX: M X | F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: 04 20 1937 | SEX: M | F X

b. AUTO ACCIDENT? YES | NO X | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO X

c. INSURANCE PLAN NAME OR PROGRAM NAME: SHEET METAL WORKERS NAT'L

d. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICARE - MASS

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X | NO | If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE: 11-17-03

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: HETZEL, PAUL C.

17a. I.D. NUMBER OF REFERRING PHYSICIAN: A68203

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO X | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 174.9
2. 288.0
3.
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 02 02 04	02 02 04	11	1	J9070		1	88 00	11				
2 02 02 04	02 02 04	11	1	J1100		1	50 00	10				
3 02 02 04	02 02 04	11	1	J9000		1	620 00	11				
4 02 02 04	02 02 04	11	1	J7040		1	30 00	3				
5 02 03 04	02 03 04	11	1	90782		2	30 00	1				
6 02 03 04	02 03 04	11	1	J2505		2	3688 00	1				

[redacted]

25. FEDERAL TAX I.D. NUMBER: 04-3498186 SSN | EIN X

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) NO

28. TOTAL CHARGE: $ 4519 00

29. AMOUNT PAID: $ 3979 35

30. BALANCE DUE: $ 539 65

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
HETZEL, PAUL M.D.
LIC.# 039373 03/04/04
SIGNED LETTER GENERATED

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
SPRINGFIELD MEDICAL ASSOC
2150 MAIN ST, STE 1000
SPRINGFIELD, MA 01104-000

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
SPRINGFIELD MEDICAL ASSOC
P.O. BOX 219
WINDSOR, CT 06095-0000

PIN# | GRP#

MC (APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) 03/04/2004 0001842

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90). FORM BRB-1500, APPROVED OMB-1215-0055 FORM CWCP-1500. APPROVED OMB-0720-0001 (CHAMPUS)

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Date: 3/08/2004
Time: 4:25PM

Page: 1

SPRINGFIELD MEDICAL ASSOC INC
PO BOX 219
WINDSOR, CT 06095
Phone: (800) 883-5985

MEDICARE REMITTANCE NOTICE

Provider/Clinic#: N51714

Check No/EFT Trace No: 127340082
Date Paid: 2/26/2004

NAME:

500

PERF PROV.	SERVICE DATES	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PAID AMT.
N51714	2/02/2004 2/02/2004	11	011	J9000		627.00	89.76	0.00	17.95	537.24	71.81
N51714	2/02/2004 2/02/2004	11	011	J9070		88.00	56.43	0.00	11.29	31.57	45.14
N51714	2/02/2004 2/02/2004	11	010	J1100		50.00	1.00	0.00	0.20	49.00	0.80
N51714	2/02/2004 2/02/2004	11	003	J7040		36.00	16.92	0.00	3.38	19.08	13.54
N51714	2/03/2004 2/03/2004	11	001	J2505		3688.00	2507.50	0.00	501.50	1180.50	2006.00
N51714	2/03/2004 2/03/2004	11	001	90782		30.00	26.66	0.00	5.33	3.34	21.33
PT Respon: 539.65						Claim Totals: 4519.00	2698.27	0.00	539.65	1820.73	2158.62

EMPLOYEE	DEPENDENT (IF APPLICABLE)	RELATIONSHIP
		S

PROVIDER TAX I.D. #:	PATIENT ACCOUNT #
042767880	10

5/6 640

Nº 0588583

12/20/2002
DATE ISSUED

SHEET METAL WORKERS' NATIONAL HEALTH FUND
P.O. BOX 1449 • GOODLETTSVILLE, TN 37070-1449

PAY **********95DOLLARS AND 20CENTS** DOLLARS $ *****95.20**

TO THE ORDER OF

HALLMARK HEALTH SYSTEM, INC.
100 HOSPITAL RD
MALDEN , MA 02148

0588583

AUTHORIZED SIGNATURE

NON NEGOTIABLE

AUTHORIZED SIGNATURE

BankTrust Bank, Nashville
Nashville, Tennessee 37220

⑈0058858 3⑈ ⑆064000048⑆ 702139030 2⑈

SHEET METAL WORKERS' NATIONAL HEALTH FUND

P.O. Box 1449
Goodlettsville, Tennessee 37070-1449
Toll-Free 800-831-4914 Phone (615) 859-0131

SMW+ PROGRAM

EXPLANATION OF BENEFITS

FROM DATE	TO DATE	CHARGES SUBMITTED	NON COVERED	CHARGES ALLOWED	COVERED CHARGES	AMOUNT PAID
10/01/2002	10/31/2002	2720.00	.00	95.20	95.20	95.20
		2720.00	.00	95.20	95.20	95.20

NON-COVERED CODES:

REDACTED

COMMENTS:

PROVIDER: HALLMARK HEALTH SYSTEM, INC.
PARTICIPANT
COB CLAIM NUMBER: 2005050

BRADFORD MA 01835

Processed by SOUTHERN BENEFIT ADMINISTRATORS, INC.

APPROVED OMB NO. 0938-279

1 PROVIDER NAME, ADDRESS, ZIP CODE & PHONE NO.	2	3 PATIENT CONTROL NUMBER	4 TYPE OF BILL
HALLMARK HEALTH 100 HOSPITAL RD MALDEN MA 02148 0000000000			131

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-OD.	9 C-ID.	10 L-RD.	11
0042767880	100102	103102	30	0	0	0	

12 PATIENT'S NAME | 13 PATIENT'S ADDRESS

BRADFORD, MA 01835-

14 BIRTHDATE	15 SEX	16 MS	17 ADMISSION DATE	17a HR	18 TYP	19 SRC	20 D HR	21 STAT	22 MEDICAL RECORD NO.	23	24	25	26	27	28	29	30	31
02251947	F	M	10012002	07	3	2	99	01	H0081528									

32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
											A B C

38 SHEET METAL WORKERS

REDACTED 12/14/07

39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a 88	2405.80			A2	95.20
b					
c					
d					

42 REV.CD	43 DESCRIPTION	44 HCPCS/RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0250	PHARMACY		102902	1	400	000	
0280	ONCOLOGY	99212	100102	1	7300	7300	
0280	ONCOLOGY	99214	100802	1	10600	000	
0280	ONCOLOGY	99212	101502	1	7300	7300	
0280	ONCOLOGY	99213	102202	1	9100	000	
0280	ONCOLOGY	99212	102902	1	7300	7300	
0300	LABORATORY	G0001	100102	1	1400	000	
0300	LABORATORY	G0001	101502	1	1400	000	
0300	LABORATORY	G0001	102902	1	1400	000	
0305	LAB/HEMATOLOGY	85025	100102	1	3000	000	
0305	LAB/HEMATOLOGY	85025	101502	1	3000	000	
0305	LAB/HEMATOLOGY	85025	102902	1	3000	000	
0331	CHEMOTHER/INJ	Q0083	100102	1	27800	000	
0331	CHEMOTHER/INJ	Q0083	100802	1	27800	000	
0331	CHEMOTHER/INJ	Q0083	101502	1	27800	000	
0331	CHEMOTHER/INJ	Q0083	102902	1	27800	000	
0636	DRUGS/DETAIL CODE	J0640	100102	1	6000	000	
0636	DRUGS/DETAIL CODE	J9190	100102	2	2600	000	
0636	DRUGS/DETAIL CODE	Q0166	100102	1	17800	000	
0636	DRUGS/DETAIL CODE	J0640	100802	1	6000	000	
0636	DRUGS/DETAIL CODE	J9190	100802	2	2600	000	
0636	DRUGS/DETAIL CODE	Q0166	100802	1	17800	000	

50 PAYER	51 PROVIDER I/O.	52 REL. BENEFITS ASG. C.O. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
PAGE: 01 OF 02					
MEDICARE PART A	220070	Y Y	240580		
SHEET METAL WORKERS		Y Y		9520-	
		DUE FROM PATIENT			

58 INSURED'S NAME	59 P.REL	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
	01		DISABLED	UNKNOWN
	02		DISABLED	UNKNOWN

63 TREATMENT AUTHORIZATION CODES	64 ES	65 EMPLOYER NAME	66 EMPLOYER LOCATION
			EOB ATTACHED

67 PRIN DIAG CD.	68 CODE	69 CODE	70 CODE	OTHER DIAG CODES 71 CODE	72 CODE	73 CODE	74 ODBH	75 CODE	76 ADM DIAG CD.	77 E. CODE	78
1539											

79 PC	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
9						
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE

82 ATTENDING PHYS ID B72551
PENNACCHIO JOSEPH

83 OTHER PHYS ID A

OTHER PHYS ID B72551
B PENNACCHIO JOSEPH

84 REMARKS SHEET METAL WORKERS
PO BOX 1449
GOODLETTSVILLE, TN 37070-1449

85 PROVIDER REPRESENTATIVE KATHY MARINELLI 86 DATE 110702002

HIGHLY CONFIDENTIAL

APPROVED OMB NO. 0938-279

HALLMARK HEALTH 100 HOSPITAL RD MALDEN 1 MA02148 0000000000	2	3 PATIENT CONTROL NUMBER						4 TYPE OF BILL 131	
	5 FED. TAX NO. 0042767880	6 STATEMENT COVERS PERIOD FROM 100102	THROUGH 103102	7 COV D. 30	8 N-CD. 0	9 C-I D. 0	10 L-R D. 0	11	

12 PATIENT'S NAME | 13 PATIENT'S ADDRESS: BRADFORD, MA 01835-

14 BIRTHDATE	15 SEX	16 MS	17 DATE	18 HR	19 TYP	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24-30 CONDITION CODES	31
02251947	F	M	10012002	07	3	2	99	01	H0081528		

32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE DATE	36 CODE	36 OCCURRENCE SPAN FROM	THROUGH	37
											A B C

38 SHEET METAL WORKERS

REDACTED

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	88	2405.80			A2	95.20
b						
c						
d						

42 REV.CD	43 DESCRIPTION	44 HCPCS/RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0636	DRUGS/DETAIL CODE	J0640	101502	1	6000	000	
0636	DRUGS/DETAIL CODE	J9190	101502	2	2600	000	
0636	DRUGS/DETAIL CODE	Q0166	101502	1	17800	000	
0636	DRUGS/DETAIL CODE	J0640	102902	1	6000	000	
0636	DRUGS/DETAIL CODE	J9190	102902	2	2600	000	
0636	DRUGS/DETAIL CODE	Q0166	102902	1	17800	000	
0001	TOTAL CHARGES			32	272000	21900	

50 PAYER	51 PROVIDER NO.	52 REL. YES	52 REL. NO	53 ASG. YES	53 ASG. NO	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
PAGE: 02 OF 02 MEDICARE PART A	220070	Y		Y		240580		
SHEET METAL WORKERS		Y		Y			9520	
	DUE FROM PATIENT							

57 INSURED'S NAME	59 P.REL	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
	01		DISABLED	UNKNOWN
	02		DISABLED	UNKNOWN

63 TREATMENT AUTHORIZATION CODES	64 ES	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN.DIAG.CD.	68 CODE	69 CODE	70 CODE	OTHER DIAG. CODES 71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM.DIAG.CD	77 E-CODE	78
1539											

79 PC	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
9						
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE

82 ATTENDING PHYS. ID: B72551
PENNACCHIO JOSEPH
83 OTHER PHYS. ID: A
OTHER PHYS. ID: B72551 B
PENNACCHIO JOSEPH

84 REMARKS: SHEET METAL WORKERS
PO BOX 1449
GOODLETTSVILLE, TN 37070-1449

85 PROVIDER REPRESENTATIVE: KATHY MARINELLI 88 DATE: 11072002

MEDICARE NATIONAL STANDARD INTERMEDIARY REMITTANCE ADVICE

HALLMARK HEALTH SYSTEMS
100 HOSPITAL ROAD
MALDEN MA 02148

PROVIDER: 220070 MEDICARE
ENDING: 10/31/2002
BILL TYPE: 131

NAME:
HIC:
MRN: H0081528

PCN: V19070457 1
ICN: 1231539763

SERVICE: 10/01/2002 THRU 10/31/2002
MEDICARE PAYMENT DATE: 12/03/2002
PAT STAT: 01 CLAIM STAT: 1

CHARGES		PPS DATA		PAYMENT DATA	
REPORTED	2720.00	DRG	000	REIMB RATE	0.00
NON-COVERED	219.00	DRG AMOUNT	0.00	PROF COMP	0.00
DENIED	0.00	DRG/OPERATION	0.00	PERDIEM	0
		DRG/CAPITAL	0.00	INTEREST	0.00
		OUTLIER( )	0.00		
DAYS					
		BLOOD DEDUCT	0.00		
COVERED DAYS	0000	TOTAL DEDUCT	0.00	CONT ADJ AMT	1957.70
NON-COVERED DAYS	0000	CO-INSURANCE	95.20	NET REIMB AMT	448.10

REDACTED

[redacted]

[redacted]

REDACTED

09/13/2001
Date Issued

Amount Paid: [redacted] $4.54

NEW BEDFORD, MA 02740

File Copy This is not a Check

SHEET METAL WORKERS' NATIONAL HEALTH FUND
P.O. Box 1449
Goodlettsville, TN 37070-1449
Phone (615) 859-0131 Toll-free (800) 831-4914

Claim No. **1535299**

Check No. **0058078**

Explanation of Benefits **SMW+ Program**

Dates of Service From	To	Amount Charged	Non-Covered Charges	Covered Charges Allowed	Major Med Maj Med	Paid
12/29/2000	12/29/2000	$57.00	$0.00	$4.54	$4.54	$4.54
[redacted] Total		$57.00	$0.00	$4.54	$4.54	$4.54

Comments:

REDACTED

[redacted]

SULLIVAN, FREDERICK
221 RICHMOND ST
NEW BEDFORD, MA 02740

Participant SSN: [redacted]
MPC Claim Number: 1535299

Processed by *Southern Benefit Administrators, Inc.*

HCFA MEDICARE MEDICAID

Medicare Summary Notice

January 29, 2001

REDACTED

FREDERICK J SULLIVAN
221 RICHMOND ST
NEW BEDFORD MA 02740-5620

CUSTOMER SERVICE INFORMATION

If you have questions, write or call:
National Heritage Insurance Company
P.O. Box 1000
Hingham, MA 02044

Local: (781) 741-3300
Toll-free: 1-800-882-1228
TTY For Hearing Impaired: 1-800-559-0443

HELP STOP FRAUD: Always review your Medicare Summary Notice for correct information about the items or services you received.

This is a summary of claims processed from 01/02/2001 through 01/26/2001.

PART B MEDICAL INSURANCE - ASSIGNED CLAIMS

Dates of Service	Services Provided	Amount Charged	Medicare Approved	Medicare Paid Provider	You May Be Billed	See Notes Section
Claim number 01-00356-057-390						
Andrew J Dadagian Md In, C, Roman House Annex, 386 County St , New Bedford, MA 02740-4932						
Dr. Dadagian, Andrew J. M.D.						
12/11/00	1 Remove impacted ear wax (69210)	$80.00	$51.21	$40.97	$10.24	
Claim number 02-01011-460-700						
Hawthorn Medical Associ, P.O. Box 3076, Boston, MA 02241-0001						
Dr. Charnond, Siroth M.D.						
11/22/00	4 Methotrexate sodium inj (J9260)	$24.00	$18.04	$14.43	$3.61	a
11/22/00	1 Injection, sc/im (90782)	33.00	4.66	3.73	0.93	
Claim Total		$57.00	$22.70	$18.16	$4.54	

MR 9-12

PMED34
081800
VER1

THIS IS NOT A BILL - Keep this notice for your records.

PART B MEDICAL INSURANCE - ASSIGNED CLAIMS (continued)

REDACTED

Dates of Service	Services Provided	Amount Charged	Medicare Approved	Medicare Paid Provider	You May Be Billed	See Notes Section
Claim number 02-00356-544-050						
Hawthorn Medical Associ, P.O. Box 3076, Boston, MA 02241-0001						
Dr. Egan, Michael W. M.D.						
12/13/00	1 Flu vaccine, 3 yrs, im (90658)	$25.00	$4.92	$4.92	$0.00	b
12/13/00	1 Admin influenza virus vac (G0008)	8.00	4.66	4.66	0.00	b
12/13/00	4 Methotrexate sodium inj (J9260)	24.00	18.04	14.43	3.61	a
12/13/00	1 Injection, sc/im (90782)	33.00	0.00	0.00	0.00	c,a
Claim Total		**$90.00**	**$27.62**	**$24.01**	**$3.61**	
Claim number 02-00363-395-520						
Hawthorn Medical Associ, P.O. Box 3076, Boston, MA 02241-0001						
Dr. Davidson, Gail M.D.						
12/20/00	4 Methotrexate sodium inj (J9260)	$24.00	$18.04	$14.43	$3.61	a
12/20/00	1 Injection, sc/im (90782)	33.00	4.66	3.73	0.93	
Claim Total		**$57.00**	**$22.70**	**$18.16**	**$4.54**	
Claim number 02-01011-456-170						
Hawthorn Medical Associ, P.O. Box 3076, Boston, MA 02241-0001						
Dr. Egan, Michael W. M.D.						
12/29/00	4 Methotrexate sodium inj (J9260)	$24.00	$18.04	$14.43	$3.61	a
12/29/00	1 Injection, sc/im (90782)	33.00	4.66	3.73	0.93	
Claim Total		**$57.00**	**$22.70**	**$18.16**	**$4.54**	
Claim number 02-01018-441-100						
Hawthorn Medical Associ, P.O. Box 3076, Boston, MA 02241-0001						
Dr. Egan, Michael W. M.D.						
01/05/01	1 Injection, sc/im (90782)	$33.00	$4.96	$0.00	$4.96	d